Debriefing: Confusion and Controversy

Multiple Definitions in the Disaster Response Community

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Edward M. Kantor, M.D., Assistant Professor of Psychiatric Medicine
Faculty Director, UVA Medical Reserve Corps
Department of Psychiatric Medicine, University of Virginia School of Medicine
Commonwealth of Virginia, Terrorism and Disaster Behavioral Health Advisory Council

Jack Herrmann, MSEd., NCC, Assistant Professor of Psychiatry (and Clinical Nursing)
Department of Psychiatry and Center for Disaster Medicine and Emergency Preparedness
University of Rochester Medical Center

In an attempt to offer clarification to the Medical Reserve Corps community, we have put together a short statement about "debriefing". The issue arose at the National Leadership Conference in Baltimore (July 2004) and was clearly the subject of many perspectives, opinions and variant definitions. Hopefully this will help MRC unit leadership as they develop and implement plans related to mental health- if noting else, it may drive us toward a common terminology and further discussion.

OVERVIEW

Debriefing as a term can mean many things. Even in Emergency Services and Disaster Operations there is no uniform application of the term. It is extremely important to understand these different meanings to ensure that we are communicating the correct message and also providing appropriate care for those exposed to traumatic events, including victims, families and response personnel.

OPERATIONAL DEBRIEFING

Operational Debriefing is an organizational process implemented after a major event or training exercise to review the process of the response and focus on successes and failures of an operation. The primary intent of operational debriefing is to gather information about the event for leadership and to convey important "lessons learned" to the participants. It has been used by military and civilian agencies extensively for intelligence gathering and informational purposes, providing an evaluative or quality improvement component to response activities and field operations.

PSYCHOLOGICAL DEBRIEFING

Although there are many variant applications, Psychological Debriefing is a technique of early intervention employed after traumatic events and exposures with the intent of helping an individual process the event and it's linked emotional content.

It is not the only tool available to help survivors, victims and responders of emergencies and disasters. The most widely used form of Psychological Debriefing in Emergency Services is Critical Incident Stress Debriefing or CISD (developed by Jeffrey Mitchell and George Everly). Their strategy has evolved into more of a toolbox of responses known as Critical Incident Stress Management or CISM, where a fairly structured format of debriefing may be part of the package. Mitchell and Everly have reportedly acknowledged that one of the difficulties "is the confusion over terms and the failure of methodologies to evaluate their specific model of debriefing in the situation for which it was developed (i.e. emergency services) and as part of a comprehensive stress management/crisis intervention framework."(1)

Recently NIMH held a consensus conference on disaster mental health in an attempt to clarify some of the controversies and provide guidance in the area of mental health in relation to mass violence (2). Their findings in relation to debriefing are as follows:

> *There is **some** Level 1 evidence suggesting that early intervention in the form of **a single one-on-one recital of events and expression of emotions** evoked by a traumatic event (as advocated in **some forms** of psychological debriefing) **does not consistently reduce risks** of later developing PTSD or related adjustment difficulties.*
>
> *Some survivors (e.g., those with high arousal) may be put **at heightened risk for adverse outcomes** as a result of such early interventions.*

SUMMARY AND RECOMMENDATIONS

It is becoming clear across all the Emergency and Disaster Mental Health disciplines that there is no "one size fits all" approach to the behavioral health issues surrounding disaster and bioterrorism. It is thus critical that those responsible for community planning and response begin to develop an integrated and flexible mental health response plan that is guided by the evidence--when evidence exists.

The disaster mental health response begins long before a disaster occurs and should be an integral and integrated part of the overall disaster plan with an early focus on community education and expectations, risk communication methods and content, triage and screening both on the scene and in hospitals, as well as post-event availability of psychoeducation, community resilience activities, individual and group crisis counseling and more definitive mental health treatment when indicated. Furthermore, the responsibility for providing supportive interventions during disaster can and should extend beyond just the mental health professional alone. Educating and training all disaster responders in the provision of psychological "first aid" or comfort care, strengthens the overall disaster response and ensures that those individuals impacted by disaster and its aftermath have a greater opportunity to have their psychological needs addressed early on and as a result, potentially mitigate any long term psychological consequences.

(1) Raphael, Beverly, et.al. (Editors), (2000) Psychological Debriefing, Theory, Practice and Evidence Chapter 5: Critical Incident Stress Management and Critical Incident Stress Debriefings: evolutions, effects and outcomes. (pp 71-90) London: Cambridge University Press

(2) Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence. A Workshop to Reach Consensus on Best Practices. NIH Publication No. 02-5138, Washington, D.C.: U.S. Government Printing Office.